Kansas
Department of Health and Environment
Division of Health Care Finance

STATE EMPLOYEE HEALTH PLAN (SEHP)
Revocation of Personal Representative

Member ID Number or Social Security Number _____

Member Information

Member, Spouse or Dependent Names (LAST, FIRST, MI)	Mailing Address STREET ADDRESS CITY, STATE, ZIP	Phone Number INCLUDING AREA CODE

Personal Representative Information

Personal Representative Name (LAST, FIRST, MI)	Mailing Address STREET ADDRESS CITY, STATE, ZIP	Phone Number INCLUDING AREA CODE	Relationship to the Member

I, the above named member, hereby revoke the above named person, to:

- ❑ Act on my behalf or,
- ❑ Act on behalf of my covered spouse / dependent(s) named below:

I revoke the designation of Personal Representative for the above named individual in receiving any protected health information (PHI) that is or would be provided to me as a member / beneficiary of the SEHP, including any individual rights that I have regarding my PHI under the Health Insurance Portability and Accountability Act (HIPAA) effective

I understand that PHI has or may already have been disclosed to the above named Personal representative in accordance with the previous appointment and **prior** to the effective date of this revocation.

Member's Signature: _____ **Date:** _____